SPECIALISTS IN PEDIATRIC DENTISTRY
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CHILD CONFIDENTIAL HEALTH HISTORY FORM

Please fill out all applicable information completely.

Patient's Name: _____ Birthdate: _____ SS#: _____

Current Gender Identity: (Check ALL that apply) ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Choose not to disclose

Sex Assigned at Birth: (Check one) ☐ Female ☐ Male ☐ Choose not to disclose

Residence/Street: _____ City: _____ State: _____ Zip Code: _____

School: _____ Grade: _____ E-mail: _____

Home Phone: _____ Cell Phone #1 Parent/Guardian: _____ Cell Phone #2 Parent/Guardian: _____

Parent(s)/Guardian(s) Name: _____ Employer: _____ SS#: _____

Business Address: _____ Business Phone: _____ Marital Status: M S W D

Parent(s)/Guardian(s) Name: _____ Employer: _____ SS#: _____

Business Address: _____ Business Phone: _____ Marital Status: M S W D

Emergency Contact and Phone: _____ Whom may we thank for referring you? _____

Business Address: _____ Business Phone: _____

Emergency Contact and Phone: _____ Whom may we thank for referring you? _____

Names and ages of other children: _____

DENTAL HISTORY

Current Dentist Name: _____

Address: _____

Phone: _____

Chief Oral Complaint: _____

Date of Last Dental Exam: _____

Has patient had any unfavorable dental experiences?: ☐ Yes ☐ No

If so, please explain _____

_____

DOES THE PATIENT HAVE OR USE ANY OF THE FOLLOWING?
PLEASE INDICATE WITH AN (X)

- ☐ Traumatic injury to mouth or teeth
- ☐ Sensitivity to cold/hot/sweet/pressure
- ☐ Bleeding gums/How long _____
- ☐ Food impaction
- ☐ Clenching or grinding of teeth
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ears
- ☐ Bad Breath
- ☐ Complications from extractions
- ☐ Topical Fluoride treatment
- ☐ Orthodontic Treatment
- ☐ Mouth breathing
- ☐ Oral habits: nail biting, cheek biting, tongue thrusting
- ☐ Toothbrush Texture _____
- ☐ Brushing frequency _____
- ☐ Dental Floss
- ☐ Disclosing tablets/solutions
- ☐ Fluoride supplements
- ☐ Between meals snacks
- ☐ Well-balanced diet

MEDICAL HISTORY

Physician's Name: _____

Address: _____

Phone: _____

Date Last Medical Exam _____ Height :_____ Weight: _____

DOES THE PATIENT HAVE OR HAS THE PATIENT HAD ANY OF THE FOLLOWING?
PLEASE INDICATE WITH AN (X)

- ☐ Allergies (medication, food, other _____)
- ☐ Anemia or blood problems (Sickle Cell)
- ☐ Arthritis/Joint pain
- ☐ Asthma/Breathing problems
- ☐ Bleeding problems
- ☐ Bone or Muscular problems
- ☐ Bronchitis
- ☐ Cancer/other Tumors
- ☐ Cerebral Palsey
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Ear/Hearing difficulties
- ☐ Endocrine/Glandular problems
- ☐ Eye/Vision problems
- ☐ Handicaps (mental,physical, emotional)
- ☐ Heart defects
- ☐ Hepatitis/Jaundice
- ☐ Hospitalization _____
- ☐ Immuno Suppressive (A.I.D.S.) Disease
- ☐ Kidney/Urinary Tract problems
- ☐ Learning Disorders
- ☐ Measles
- ☐ Mumps
- ☐ Nervous/Seizure problems
- ☐ Pregnancy
- ☐ Rheumatic Fever
- ☐ Radiation Treatments
- ☐ Scarlet Fever
- ☐ Sickle Cell Trait or Disease
- ☐ Stomach/Digestive problems
- ☐ Venereal Disease

Describe any current medical treatment including drugs taken, even though not listed above:

_____

_____

Is there anything else that you feel Affiliated Dental Specialists should know about the patient?

_____

_____

I certify that I have read and understand the above questions.
I will not hold Affiliated Dental Specialists responsible for any errors or omissions I may have made in completion of this form.

Signature of Person Completing Form: _____

Relationship to Patient: _____ Date: _____

DEERPATH PROFESSIONAL BUILDING
ONE E. PHILLIP RD., SUITE 102
VERNON HILLS, IL 60061
Call: 847.367.6055
Fax: 847.367.6079

GURNEE MEDICAL OFFICES
36100 N. BROOKSIDE DR., SUITE 205
GURNEE, IL 60031
Call: 847.263.1842
Fax: 847.367.6079

AFFILIATEDDENTALSPECIALISTS.COM

CHILD AGREEMENT AND CONSENT TO RENDER DENTAL CARE

APPOINTMENTS: Each appointment represents a specific amount of time reserved for a patient's dental care. If some problem arises so that you are unable to keep this appointment, Affiliated Dental Specialists (ADS) **requires notification not less than 24 hours prior to the scheduled appointment** or it will be considered a failed appointment. ADS reserves the right to assess a failed appointment fee based upon our then existing schedule of rates.

ADS will make every effort to schedule appointments for our patients as convenience permits. However, there are times to provide quality care and/or for a patient's comfort and well-being, to appoint them at a time that may conflict with work or other activities. ADS makes every effort to honor appointments with a minimum of waiting time. Therefore, it is important that our patients arrive for appointments promptly and ready for a scheduled treatment. **(ADS reserves the right to reschedule an appointment due to a patient's failure to arrive for a scheduled appointment in a timely manner.)**

FEES AND INSURANCE: Each fee is individual for the services rendered and due at the time of services unless formal written arrangements are made prior to receiving those services. To avoid misunderstanding regarding fees and dental insurance, be aware **that all professional services rendered are charged directly to the responsible parties/persons indicated and they are responsible for payment of fees.** ADS is happy to assist in filing insurance claims, however, the filing of an insurance claim(s) does not assure that the insurance companies will pay all fees. The fees for services rendered remain your responsibility.

CONSENT: State law requires ADS to obtain consent for a patient's dental treatment. Please read carefully and sign at the bottom where indicated.

I hereby represent and warrant that I am the custodial parent and/or legal guardian for the hereinafter indicated child and that I have been granted the right by court order or judgement to make medical and dental decisions concerning the care and/or treatment of this child. In the event that I am unable to personally attend my child's dental treatment appointments, I hereby appoint_____, as my agent and authorize you to accept direction from said person concerning the treatment of my child and to release information to that person as you feel is necessary in connection with treatment rendered or to be rendered. This appointment shall be valid until terminated in writing directed to ADS. I hereby authorize to have my child or myself treated for the necessary diagnostic (examination, radiographs, photographs) and/or emergency treatment that may be deemed necessary. ADS will inform me of all other services and corresponding fees prior to treatment.

I also understand that I am responsible for all fees for services rendered. If ADS seeks enforcement of this agreement through the services of a collection agency, I shall be responsible for any incidental expenses including all collection costs and reasonable attorney's fees. I hereby authorize the release of all information necessary or convenient to the collection of outstanding charges or the enforcement of this agreement.

I hereby acknowledge that I have read and understand this Agreement and Consent form, that I have been given an opportunity to ask questions, and that all questions about the procedure(s) have been answered in a satisfactory manner; and I understand that I have the right to be provided with answers to questions which may arise during the course of treatment.

I further understand that I may withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I choose to terminate it in writing.

Finally, I acknowledge that I have received and read a copy of the ADS Notice of Privacy Practices.

Patient's/Responsible Party's Name: _____

Signature of Parent or Guardian (Responsible Party): _____

Date: _____ Time: _____

Witness: _____

I certify that I explained the above procedures to the patient.

Signature of Dentist: _____ Date: _____